92-04521/

RURAL HEALTH SERVICES TASK FORCE

INTERIM REPORT TO

HEALTH ADVISORY NETWORK

SEPTEMBER, 1990

Manitoba
Health

GLOSSARY

M.H.S.C.	- Manitoba Health Services Commission
M.I.C.H.S.C.	- Manitoba Institution and Community Health Services Commission (Proposed)
S.C.O.M.M.	- Standing Committee on Medical Manpower
W.H.M.I.S.	- Workplace Hazardous Materials Information System
WH & S	- Workplace Health & Safety
locum tenens	- A physician temporarily replacing the permanent physician
MCCEE	- Medical Council of Canada Evaluating Examination
LMCC	- Licentiate Medical Council of Canada
B.N.	- Bachelor of Nursing
R.N.	- Registered Nurse
R.P.N.	- Registered Psychiatrc Nurse
L.P.N.	- Licensed Practical Nurse
O.T.	- Occupational Therapy
P.T.	- Physiotherapy
M.H.O.	- Manitoba Health Organiazations, Inc.
LAXUS	- Provincial Laboratory and X-Ray Services

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1. INTRODUCTION:

The Health Advisory Network was initiated by the Honourable Donald Orchard, Minister of Health, in May 1989 as a means to assist in the planning for reform and improvement of present health care services in Manitoba.

A Steering Committee was appointed in May 1989 with the following terms of reference:

1. To undertake such investigation and analysis of specific issues in the organization, administration and financing of health services, as may be referred to the committee by the Minister, or as the committee may deem appropriate, and to report thereon to the Minister.

2. To establish Task Forces to use such other means as may be deemed appropriate by the committee for the purpose of undertaking the investigations and analyses required by the Committee in order for it to tender soundly based advice.

3. To inform both the general public and the health services community about the matters being addressed by the Health Advisory Network.

One of the first Task Forces to be formed was the Rural Health Services Task Force. In September of 1989 the following terms of reference were given:

1. Review and make recommendations on the supply and organization of health care services in rural Manitoba.

2. Recommend means to improve recruitment and retention of physicians and other health professionals.

3. Consider cost-effective means to expand the scope of health services in rural regional hospitals which may reduce interhospital transfers to Winnipeg.

The aim of the Task Force is to address known health service delivery problems associated with several factors - a) declining population numbers, b) growing percentage of elderly residents, and c) ongoing difficulties in recruiting health care professionals to small communities.

The first task of the committee was to review literature, research papers and annual reports of the M.H.S.C., S.C.C.M.M., and Manitoba Health.

To gain a better understanding of the present rural health scene various members of the health field were asked to present their views on the current practice of health care in rural Manitoba as well as to provide the Task Force with their ideas on ways to improve the service. This included people from the Medical and Nursing professions, both education and licensure, M.H.S.C. and Manitoba Health officials and various Rural Health Districts (Appendix A).

In February 1990 the Task Force held public meetings at six centres throughout Manitoba where the public, health professionals, and municipal officials were asked to bring information and syggestions to help set the future direction of health care in rural Manitoba. The meetings were held at Carman, Souris, Shoal Lake, Dauphin, Teulon and Steinbach. Response by the hospitals and care homes was good however, general public participation was minimal. Over 200 people, representing 72 towns or municipalities of rural Manitoba, attended these meetings. Over 60 verbal and written presentations were received from health facility administrators, Hospital Board Chairpersons, nurses, municipal councillors/mayors, interested health groups and citizens. See Appendix B.

We would like to take this opportunity to thank all of those presenters who gave so generously of their time and understanding so that this report could be meaningful. We hope that we have accurately reflected their concerns and have been able to come to some acceptable recommendations.

Many problems were heard relative to the delivery of mental health, or rather lack of programs in rural Manitoba, however we have not attempted to deal with them in this report. It is suggested, however, that this area be dealt with by another task force if this has not already been done. We are more than willing to share with them any of the reports we received regarding mental health issues.

As well, the services for the elderly have not been dealt with specifically, however, in proposing the delivery system that we have, with services and control of the programs closer to home, we feel that it will be of great benefit to the rural elderly. It is also understood that a Task Force on Extended Care services in Rural Manitoba is to be appointed who will no doubt deal with the personal care homes as it has done for Winnipeg.

In making its recommendations the Task Force realizes that there may be many solutions to the problems presented to us. We believe that many of the concerns expressed by the people at the public hearings and those whom we asked to present to us are valid and need to be addressed expeditiously. We also recognize that we are not experts and have recommended that consultants who have the expertise in the various areas of concern should be hired to assist in the validation of our recommendations and also in the implementation deemed appropriate.

2. **TASK FORCE MEMBERS:**

Zella Mills, R.N. - Co-Chairman	Works part time for Home Care in Brandon. Was a member of Brandon General Hospital Board and is presently a member of the Manitoba Health Organizations, Inc. Board.
Dwight Hopfner - Co-Chairman	A farmer from Ste. Rose du Lac. Chairman of the Ste. Rose General Hospital Board and Reeve for Municipality of Ste. Rose.
Pat Gibson, R.N.	Presently Director of Patient Services at Morden General Hospital and will be assuming the position of Regional Planner for the proposed Morden-Winkler Hospital amalgamation in July 1990.
Jim Westwood	C.E.O. of Wawanesa, Glenboro, Baldur and Treherne health care facilities. Also a member of M.H.O. Board.
Ron Renwick	Farmer from Coulter. Member of Melita/Deloraine Hospital Board and Reeve of Municipality of Arthur.
Dr. Gary Hansen, M.D.	Active surgeon at Carman General Hospital.
David Lethbridge	Air traffic controller from Stonewall. Mayor of Stonewall and presently a member of the Standing Committee on Medical Manpower.
George Bass, Q.C.	A lawyer practicing in Brandon and Neepawa. Currently a member of M.H.S.C. Board and acting as liaison between M.H.S.C. and the Task Force.
Lloyd Shelvey	Merchant from Rapid City. Is Past Chairman of M.H.O. Board and a member of the Health Network Steering Committee, acting as a liaison between it and the Task Force.
Darien Briggs, R.N. - Secretary	Free-lance consultant. Formerly Director of Rural Facilities Division of M.H.S.C.

Our recommendations are made with the sincere belief that the following can and will be accomplished:

1) A decrease in the need for costly transfers to the Winnipeg hospitals when more services are provided closer to home.

2) A greater ability to recruit and retain health care professionals when a broad spectrum of health care is offered regionally (up to and including secondary acute care) and the collegial supports and amenities are available.

3) An improved linkage of institutional and community based and preventative health services to achieve a more effective system where the continuum of care is more integrated.

4) A sense of ownership of the health care system by the people who receive and supply the service in rural Manitoba with the establishment of Regional Councils who will have greater participation, responsibility and accountability for the decisions regarding health care delivery in their region.

It is understood that some of these recommendations impact on both Urban and Northern Manitoba. We have attempted to address the needs of Rural Manitoba as a part of the whole. While the recommendations are fairly detailed in some areas the model we have outlined could be accommodated within a comprehensive plan for the province. In developing a comprehensive plan regardless of what model is used the basic principles to which we have alluded should be retained.

Although this report represents the concensus of the opinions of the members of the Task Force neither it nor any of its parts should necessarily be taken as being the opinion of any of the individual members, their employer, any organization to which they may belong or any institution to which he or she may belong or represent.

EXECUTIVE SUMMARY

INTRODUCTION:

Terms of Reference of Rural Task Force are:

1) Review and make recommendations on the supply and organization of health care services in Manitoba.

2) Recommend means to improve recruitment and retention of physicians and other health professionals.

3) Consider cost effective means to expand the scope of health services in rural regional hospitals which may reduce interhospital transfers to Winnipeg.

The Task Force reviewed the current literature and held meetings with health professionals as well as public meetings to gain an understanding of some of the problems and proposed solutions. Mental Health area was not reviewed.

In making its recommendations the Task Force realizes that there may be many solutions to the problems presented to us. We believe that many of the concerns expressed by the people at the public hearings and those whom we asked to present to us are valid and need to be addressed expeditiously. We also recognize that we are not experts and have recommended that consultants who have the expertise in the various areas of concern should be hired to assist in the validation of our recommendations and also in the implementation deemed appropriate.

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Pat Gibson, R.N.
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Dr. Garry Hansen
David Lethbridge
George Bass, Q.C.
Lloyd Shelvey
Darien Briggs - Secretary

I. ORGANIZATION OF HEALTH CARE SERVICES IN RURAL MANITOBA

Two main areas of concern were expressed by many:

1) Lack of organization and direction of the health care delivery system in Rural Manitoba; overlapping services, service gaps, inability to access service, and general confusion by the maze of government agencies involved in providing "health care: were given to us as examples;

2) The feeling of lack of input into decisions that mare made regarding programs that are delivered to Rural Manitobans. It was the impression of many that decisions made were made by city people for city programs with very little understanding or knowledge of Rural Manitoba needs, geography or abilities.

In reviewing some literature and in some of the presentations the concept of more control closer to home and of an integrated approach to health care (institutional care and community services) became evident. It was important to maintain the local Board while vesting some of the provincial control in Regional Councils which would be made up of representatives from the local Boards. As the present Manitoba Health Regional Offices and some staff are already in existence, it was not seen to be adding another layer of bureaucracy but rather decentralize some of the authority of the present M.H.S.C.

With the number of present local Board becoming incorporated under the District Health and Social Services Act (44) in total, the ability for the Boards to integrate the institutional and community services is there. The direction for such a move must also come from the top so that hospital and community programs meet together rather than fight each other for control and finances. With the development of Regional Councils with control over all aspects of health care they will be able to put their financial resources in the direction most needed in that region be it health promotion, transportation, community care or institutional care.

Present ambulance services are operated by various means - private, fire department, municipality or hospital and receive money in the form of grants either directly or through the municipality. They are seen as a part of the health care system and could be integrated with the other health care services in the region.

With more responsibilities the Board and Regional Council members must be able to obtain the educational resources for themselves necessary to direct the health care in their communities.

RECOMMENDATIONS:

The Task Force therefore recommends:

I.1 M.H.S.C. and Manitoba Health, Division of Community Health Services, should be amalgamated to achieve a more effective system where the continuum of care would be more integrated. Within this report the amalgamated entity will be referred to as the Manitoba Institutional and Community Health Services Commission - M.I.C.H.S.C.

I.2 This amalgamation should retain a Board structure which would report to the Minister of Health (see organizational chart Appendix C.)

I.3 That the programs presently delivered by the Regional Health Offices for the Department of Community Services i.e. Child Welfare and Child Day Care, be transferred from the Department of Community Services to Department of Health, Division of Community Services and subsequently to MICHSC. This would assure that the Regional Director would have only one Department of Government to report to and would assist in further consolidating program delivery.

I.4 The present 5 Rural Health Regions' mandate should be expanded to include responsibilities for organizing and delivering health care for the acute and long term institutions, ambulance, as well as those health and social services they presently deliver.

I.5 The local facility Boards should be maintained. They should assume the responsibilities for the ambulance services, community health and social services programs for their district where appropriate.

I.6 That an authority called the "Regional Council" be established within each of the regions to manage the health care programs within its mandate.

I.7 That the "Regional Council" should be made up of representatives from each of the Local Boards in the region; local physicians, and government appointment as necessary - see Appendix D.

I.8 That the Regional Council should have the authority and responsibility for all aspects of health care, including program planning, standards, evaluation, and budget allocation for acute care, long term care, ambulance services and community health and social services within the Region and to ensure access to those programs that cannot be delivered locally or within the region.

The Council should be accountable to their residents and to the M.I.C.H.S.C. for financial management and program delivery within the region.

I.9 That a member of each of the Regional Councils should be appointed to the M.I.C.H.S.C. Board.

I.10 To ensure adequate funding for an integrated and comprehensive health program, legislation and policies must be developed by the provincial government as well as by Regional Councils which define the basis on which the Regional Council will obtain funds and decide on their allocation.

I.11 That all funding policies and program standards will be shared with the users in written form.

I.12 That to implement the amalgamation of M.H.S.C. and Community Health Services of Manitoba Health, a strategic plan should be developed by appropriate consultants who have expertise on organization development, strategic planning, resource allocation, legislation, funding and administration, and that such a plan be put into effect.

I.13 That policies be developed to ensure that employees who now work for government or other health agencies and who would be transferred to local Boards retain their benefits and levels of compensation to the greatest degree possible.

I.14 That inter-facility ambulance transfers should become an insured service.

I.15 That consultation be undertaken by Manitoba Health and the Manitoba Health Organizations Inc. for the development and implementation of a funded, portable, comprehensive orientation and continuing education program (similar in substantiveness to that available to municipal councillors) for members of Regional Councils and Local Boards.

I.16 That the Manitoba Health and the Manitoba Health Organizations, Inc., examine the benefits of an elected local facility Board similar to the School Trustee elections.

I.17 That all facility Board members should be paid out of pocket expenses and a reasonable stipend for their services

II. INSTITUTIONS:

The need to define the role of these facilities becomes obvious when one considers that some of the smaller facilities may not be able to attract a physician in the future but some form of health care delivery still should take place in the existing facility. The larger facility's programs must therefore expand and be able to serve a wider area through more shared service arrangements. Within a region one could foresee the development of an integrated health care system that encompassed basic, primary, intermediary and secondary health care delivery areas, each with their own role within the region but each functioning in cooperation with the other.

Be defining these areas it is considered that the following benefits may accrue:

- planning for construction, equipment, staffing and funding will be based on a regional program and take into consideration the ability to share services, not duplicate or overlap them.

- the ability to attract physicians to the smaller areas if a reasonable sharing of services and ability to practice in cooperation with a larger hospital where surgery or obstetrics is being practiced.

- by defining services in a secondary hospital it is hoped that more specialists will be attracted there as their area of practice would be enlarged to encompass the whole region. As well, the residents of that region will not by-pass the secondary hospital but would be able to receive the majority of their health care services there rather than in Winnipeg.

- better utilization of facilities (e.g. if a community loses their physician the hospital need not close - other programs could take over and provide the needed care on a shared basis with the neighbouring community).

- the development of standards that are reflective of the program parameters.

RECOMMENDATIONS:

The Task Force therefore recommends:

II.1 That the following description of "Health Service Delivery Areas" be considered by the Regional Councils as working definitions for the purposes of planning and programming within each Region.

Each Health Service Delivery Area:

1. provides the program on-site (includes part time or shared service arrangements on a continual regular basis).

2. providers of service may come from somewhere else.

3. describes minimum requirements.

The following Health Service Delivery Areas be considered as working definitions within each Region:

i) Basic Health Service Delivery Area:

May include, but not be limited to:

- **personal care in-patient services**
- **out-patient services**
- **medical services**
- **community health and social services**
- **ambulance services**
- **nursing services**

ii) Primary Health Service Delivery Area:

May include, but not be limited to:

- in-patient acute and convalescent care
- in-patient personal care
- out-patient services
- emergency services
- surgical services limited to Schedule A of the College of Physicians and Surgeons (see Appendix - minor surgical procedures - no general anesthetic)
- low risk obstetrics
- medical services
- diagnostic services schedule
- general nursing services - 24 hour RN coverage
- pharmacy services
- ambulance service
- community health services - those services presently provided from Region
- social services - those services presently provided from Region

iii) Intermediate Health Services Delivery Area:

May include, but not be limited to:

- all of the above service plus
- surgery - Schedule B of the College of Physicians and Surgeons (see Appendix)
- anesthesia
- obstetrics commensurate with Schedule B of the College of Physicians and Surgeons
- diagnostic services to include:
  - fluoroscopy
  - ultrasound
  - portable x-ray
  - blood gases
- therapy program, i.e. P.T. and O.T.
- dietary counselling/diabetic and B.P.
- pharmacy
- community health and social services programs

iv) Secondary Health Service Delivery Area:

May include, but not be limited to:

- all of the above plus
- Medical Specialists in:
- Pediatrics/Obstetrics
- Psychiatry
- Radiology
- Internal Medicine
- General Surgery
- Anesthesia
- Pathology
- Nursing services will be organized by specialty

- **Above specialty's will require support space, staff and equipment, where necessary**
- **Rehabilitation program**
- **Dialysis**
- **Chemotherapy**
- **Diagnostic services - mammography, nuclear medicine, CAT scan**
- **Educational programs in Medicine, Nursing, Therapies**
- **24-hour medical emergency room coverage**
- **N.F.A. surgical program**
- **full time ambulance attendants**
- **all Community Health Service programs**
- **Social Service programs**
- **Respirology**

III. EDUCATION:

There are barriers for rural students to receive the same opportunity for professional education as their city counterparts. Not only is the financial burden heavier on the family but the student must leave family and friends to enter a new world.

Compounding this, accurate information regarding entrance requirements to some of the professions is not always available. Required courses may not be available locally and distance education at present is minimal.

RECOMMENDATIONS:

III.1 **That appropriate financial support in the form of bursaries or forgivable loans, be made available for students of health professions from Rural Manitoba seeking post secondary education.**

III.2 **That high schools be well informed of the entrance requirements for the various health professions when advising students on course and career selection.**

III.3 **That the Department of Education establish as a priority the development of alternative programs and services to deliver high school education to rural areas to redress the present imbalance of opportunity. The development of distance education using a variety of mediums including video/audio broadcasting, audio teleconferencing and other emerging technologies should be pursued as soon as possible for all post secondary education.**

III.4 **That the Department of Education take steps to improve articulation among Universities, Colleges and High Schools to eliminate the gaps in programming.**

III.5 **That, beginning in Grade 7, rural youth and their parents be made aware of the opportunities, the requirements and the rewards of a career in all health disciplines, through "career days", verbal presentations, and written materials. Each discipline would be responsible for its own campaign.**

IV. RECRUITMENT & RETENTION OF HEALTH PROFESSIONALS:

IV.1 MEDICAL:

According to research, if a person is originally from a rural community there is more of a chance that they will return to rural life following their education. The majority of Canadian trained physicians locating in Rural Manitoba are from the Family Medicine programs.

We heard that the rural practice of medicine is much different from the education they receive and that more skill development is required prior to practice. It would be a benefit for both their education and for the possiblity of setting up practice in Rural Manitoba if some or all of their last year of residency took place in a rural setting.

RECOMMENDATIONS:

The Task Force therefore recommends:

IV.1-1 **That the Faculty of Medicine of the University of Manitoba develop a selection criteria for admission to Medicine that would assist in the recruitment of an adequate number of graduates to practice in Rural Manitoba. That if this is unsuccessful within two years a specific number of seats may have to be set aside for rural students.**

IV.1-2 **That the University of Manitoba, through the Department of Family Medicine, research the skill as well as educational requirements, and develop a program specifically for rural family practice within the next two years.**

IV.1-3 **That Rural Manitoba hospitals and rural physicians that would qualify according to the criteria developed by the Department of Family Medicine, provide at least one of the years of residency training on site, similar to the Minnesota program. And further, that those physicians providing the training be compensated over and above their fee-for-service or existing salary.**

IV.1-4 That community hospital boards and communities work with their local physician to encourage the students who are on an "exposure" session to return to Rural Manitoba. Provision of living accommodation and/or transportation by the community would be an asset.

IV.1-5 That the Standing Committee on Medical Manpower be reconstituted as a Health Professional Manpower Council with the legislative authority to carry out the various actions necessary to ensure an adequate supply and distribution of health care professionals including, but not limited to physicians, nurses and rehabilitation therapists. And further that this Council report to the Ministers of Health and Education.

IV.1-6 That the physician resources and supporting staff required to carry out this mandate be made available.

IV.1-7 That, because of the necessity to liaise closely with the Universities, College of Physicians and Surgeons, and the Department of Immigration, the physical facilities be located in Winnipeg.

IV.1-8 That the many "exposure" programs (i.e. years 1, 2, 3 & r) now being offered through S.C.O.M.M., be evaluated with a view to either consolidating or eliminating them.

IV.1-9 That living arrangements and transportation for the Family Practice Residents while on rural rotation not be an expense to the Resident.

LICENSURE:

Until we are able to convince Canadian graduates to practice in rural Manitoba we cannot afford to lose access to foreign graduates.

The Task Force therefore recommends:

IV.1-10 That the Minister continue to provide a waiver of the MCCEE for six months when appropriate for locum tenens.

IV.1-11 That the College of Physicians and Surgeons of Manitoba take into consideration the possible ramifications to the supply of physicians for Rural Manitoba prior to making any decision regarding the attaining of an LMCC as the only entry into practice in Manitoba.

SOLO PRACTICE:

Although the majority of rural doctors today are in either a 1 or 2 doctor practice we heard that part of the reason for not being able to recruit and retain physicians in Rural Manitoba was because of just this. Solo practice dictates long hours, little time for family or vacations, little chance of colleagues supports, etc.

The community has relied on the solo practitioner and seem insatiable in their demands on the physician. Sharing of physicians services with a neighbouring community and education of the public may assist.

RECOMMENDATIONS:

The Task Force therefore recommends:

IV.1-12 That every effort be made by M.I.C.H.S.C., hospital boards and communities to allow for shared arrangements between physicians of neighbouring towns.

IV.1-13 That hospital Boards further encourages sharing of physicians by granting of admitting privileges to the neighbouring physicians when deemed appropriate.

IV.1-14 That Hospital Boards and physicians initiate a public education campaign within their communities to address the proper utilization of emergency services including use of emergency room and the on-call physician and to keep them informed of available shared medical services when appropriate.

MONETARY:

Payment of physicians is in the most part a fee-for-service arrangement. However, other arrangements such as salary or guaranteed income are becoming options.

Specialists are needed in Rural Manitoba not only for direct service but for consultation both to the patient and to the practicing physicians. Itinerant surgical programs not only provide for surgery close to home but they maintain the local hospital staff's skill levels in case of emergencies. However, as is the case with specialists, no compensation is afforded them for transportation costs or out of pocket expenses.

As with all services the paperwork and committee meetings is ever increasing. The Chief of Staff is expected to maintain his practice plus attend meetings and write reports, etc. with no compensation at present.

The Task Force therefore recommends:

IV.1-15 **That the differential between Urban and Rural physician pay schedules be maintained and that an increase in the differential be considered.**

IV.1-16 **That the Hospital Board take a more active participating role with current medical staff in determining the method of payment for the physicians in their community, i.e. fee-for-service, salaried physicians, etc.**

IV.1-17 **That a mix of methods of payment, i.e. fee-for-service, salary, etc., should be accommodated within the same medical community.**

IV.1-18 **That the Hospital Board, Medical Staff and M.I.C.H.S.C. encourage arrangements for specialists to provide some services to local communities.**

IV.1-19 **That the itinerant surgical programs be encouraged to continue with the College of Physicians and Surgeons' approval.**

IV.1-20 **That an honorarium and/or transportation and out-of-pocket expenses be paid for specialist or itinerant surgeons who take part in these programs.**

IV.1-21 **That the Chiefs of Staff of all rural hospitals be reasonably compensated for the work carried out in that role.**

IV.2 NURSING:

The confusion regarding the role of the various nursing levels and educational preparation has been going on for many years. Task Forces prior to this one have made similar recommendations regarding a coordinated effort on behalf of the nursing profession to streamline the various educational programs.

Rural nurses have a special concern similar to the physicians in that they feel ill-prepared, particularly in the area of skill levels, to perform in rural settings where they are expected to be "generalists". Orientation time provided for in the hospitals budget is too short to accommodate their needs.

Educational opportunities to upgrade are minimal for rural nurses.

RECOMMENDATIONS:

The Task Force therefore recommends:

IV.2-1 **That a Nursing Council be established which would, with the cooperation of the Universities, Colleges and Hospital Schools of Nursing, correlate and coordinate the various nursing education programs.**

IV.2-2 **That the Nursing Council be made up of representatives appointed by the M.A.R.N., M.A.L.P.N., and M.A.R.P.N., the Universities, the Colleges, the Hospital Schools of Nursing, the facilities, community health and the public.**

IV.2-3 **That the Nursing Council make recommendations to the Ministers of Health and Education with regard to the coordination of nursing education programs and a plan to implement same as soon as possible.**

IV.2-4 **That a specialty course of Rural Nursing should be developed which would meet the needs of rural nursing.**

IV.2-5 **That until the Rural Nursing Specialty course is developed, the funding authority recognize an acceptable orientation period for the new graduate nurse as determined and justified by the employer.**

IV.2-6 **That a distance education program for nurses wishing to attain the Baccalaureate degree in Nursing be made available locally from the University Faculty of Nursing as soon as possible.**

IV.3 THERAPY SERVICES:

Changing trends in health care have dramatically increased the need for rehabilitation programs which include physio and occupational therapists. As is the case with both nurses and physicians, there are barriers for rural students. The overall organization and administration of the rehabilitative services seems to be in disarray. Local control of the programs again are seen as necessary to operate them effectively.

RECOMMENDATIONS:

The Task Force therefore recommends:

IV.3-1 That, where appropriate arrangements can be made, some of the teaching or practicum of P.T. and O.T. students be spent in approved rural hospitals.

IV.3-2 That rural students receive enhanced financial support when they undertake to assume practice in Rural Manitoba.

IV.3-3 Dr. MacDiarmid's recommendation 6.3 is supported and reiterated here:
"Simplification and consolidation are the only feasibly and affordable measures, particularly for Rural Manitoba. Local control is equally practical and desirable. All presently diversified activities should be collected under one locally based administrative body. All therapists should be hired and based (i.e. resident) locally, except for highly specialized programs and extremely remote areas."

IV.3-4 That space and equipment requirements to run a rehabilitation program be provided for in new or expanded facilities.

IV.3-5 That following a positive evaluation of the geriatric rehabilitation aide program, further "aide" programs of this nature be developed and provided.

IV.3-6 That regional audiology, speech and language pathology programs be assured.

I. ORGANIZATION OF HEALTH CARE SERVICES IN RURAL MANITOBA:

To understand the problems associated with the present organization and supply of health care services in rural Manitoba we first looked at the present organization. A brief description of our understanding of the organization of the Department of Health as it relates to rural Manitoba follows:

There are basically two components of the Department of Health that affect rural Manitoba; 1) M.H.S.C., 2) Manitoba Health.

1. Manitoba Health Services Commission

Divisions of M.H.S.C., Rural Health Facilities Division, Long Term Care Programs Division, Construction Programming Division, Emergency Health and Ambulance Services Division, and Provincial Laboratory and X-Ray Services, each have a rural component.

Rural Health Facilities Division is responsible for approval of facility yearly budgets, assurance of yearly audit settlements establishment and assurance of standards of operation of rural facilities inclusive of:

a) 63 hospitals with a total of 1,628 beds arranged as follows:

 0 - 15 beds - 17
16 - 30 beds - 28
31 - 60 beds - 10
61 - 125 beds - 6

b) Five extended treatment units with a total of 109 beds.

c) 42 personal care homes with a total of 1,169 beds.

Each hospital and/or personal care home is either a part of a health district or constitutes a health district on its own. Each district has a Board of Directors that is representative of the community the health district serves. There are fourty-four (44) districts incorporated under The District Health and Social Services Act, 14 under The Health Services Acts, 1 under Non-Profit Corporation and 2 under Private Corporations Act. This myriad of different authorities presents a chaotic and confusing mechanism for administration of facilities.

Long Term Care Programs Division is responsible for approval of facility yearly budgets, assurance of yearly audit settlements establishment and assurance of standards of operation of:

a) 30 more personal care homes with 1,820 beds

b) 38 Adult Day Care Programs and

c) 16 respite care programs in rural Manitoba.

Each Personal Care Home that has not been incorporated under the District Health and Social Services Act is incorporated under various different pieces of legislation and has its own Board of Directors representative of the community.

Emergency Health and Ambulance Services Division is responsible for distribution of grants; standards, training, and licensing of 68 ambulance services, 100 vehicles and approximately 1,800 drivers and driver/attendants for rural Manitoba.

Each ambulance service has a local "committee" that is responsible for the service. Some ambulance services are operated by a committee of the local hospital Board, some of the municipality or town, some by local fire department and still others are privately operated. The majority of ambulance attendants in rural Manitoba are volunteers.

The ground ambulance service is not an insured service at this point in time except for transfers from one facility to another and returned the same day.

LAXUS directs and funds the diagnostic programs in 71 health facilities in rural Manitoba. They provide diagnostic services in medical laboratory technology, radiology, diagnostic ultrasound and electrocardiography.

206 of the 214 employees of LAXUS are stationed in the Rural Units providing direct service. All of these employees are civil servants. There are 15 units where the medical technologists are employees of the specific health facility.

Construction Programming Division provides consultative, planning and financial services to all the rural facilities both personal care homes and hospitals with regard to fire upgrading, renovations and new construction.

2. **Manitoba Health**

The Community Health Services Division of Manitoba Health is responsible for policy development, services to support the programs of Manitoba Health, and the health service delivery system provided through 10 regional offices. Five of the ten offices are located in rural Manitoba at Beausejour, Portage, Selkirk, Brandon and Dauphin. Each office has a Regional Director responsible for administrative and service delivery of the following health and social service programs; communicable disease control, audiological services, maternal and child health, health promotion, health education, home economics, service to seniors, home care, community mental health, dental health, environmental health, child and family services, mental retardation and rehabilitation, child day care and medical consultation.

Programs and fiscal controls for health programs are under the jurisdiction of Manitoba Health. Social programs such as child and family services, mental retardation and rehabilitation, and child day care are under Manitoba Community Services. Both departments maintain central office program directorates which have responsibility for development, standards control, monitoring, technical support and financial control of their programs.

Each region also maintains sub-offices in the local districts they directly serve, many of which are located in the local hospitals. Depending on the need and the availability of staff some or all of the programs are offered in each region.

The total rural population is approximately 400,000.

Areas of Concern:

Two main areas of concern that were expressed over and over again by health facility administrators, chairmen of the Health Boards, Community Workers and health care recipients were:

1) the lack of organization and direction of the health care delivery system in Rural Manitoba; overlapping services, service gaps, inability to access service, and general confusion by the maze of government agencies involved in providing "health care" were given to us as examples;

2) the feeling of input into decisions that are made regarding programs that are delivered to Rural Manitobans. It was the impression of many that decisions made were made by city people for city programs with very little understanding or knowledge of rural Manitoba needs, geography or abilities.

Repeatedly people referred to the way in which health care delivery has been fragmented and compartmentalized.

It was suggested by many that better coordination is required among the various government departments; e.g. between a) Manitoba Community Services and Manitoba Health, b) M.H.S.C. and Manitoba Health, c) within M.H.S.C. between Long Term Care Programs Division and Rural Health Facilities Division.

The Task Force heard a variety of concerns about the existing system of funding health care institutions in the province. The concerns were not so much with respect to the adequacy of funding, but about factors such as:

- inconsistencies in the rules which determine operating and capital budgets, particularly in institutional care.

- lack of incentives in the budget formula. The offer to "pick-up" the costs should you "incur a deficit" seems to provide the wrong incentive.

- lack of funding policies that respond to the health care needs of the community due to programs being approved by one government agency and funded by another.

- cumbersome and outdated method of funding equipment purchases.

- budget approvals and "year-end" settlements coming too late for any constructive financial planning to be carried out by local Boards.

- lack of recognition of the cost of putting in place and maintaining legislated programs, i.e. WHMIS and WH&S, in the small facilities.

- lack of appropriate criteria to determine staffing requirements in small acute care institutions.

One must also recognize that while the funding for institutional care has many problems they do receive the "lions share" of the health care budget. Funding for health promotion and indeed many of the community programs that are being designed to keep people out of institutions are not receiving adequate funding. With different government departments vying for their share of the money to run their programs it becomes increasingly difficult to maintain a focus. The trend seems to be away from institutional care to community services however, when the various programs of health and community services are not delivered in a cohesive manner, it becomes confusing for the recipients of the various programs to know just what organization is in charge. Local needs are being evaluated at a distance and sometimes provided from a distance, leading to a lack of community support and involvement. The community therefore responds by, in some cases, starting its own program and vying for grants, etc., from whatever government agency might be offering same.

Some programs such as Respite Care are managed by the Long Term Care Programs Division of M.H.S.C. while Home Care is managed by Community Health Services Manitoba Health. The lack of local control and the confusing organization between hospitals and community services and personal care homes leads to frustration and insecurity among the local people.

In January of 1987, Michael Decter presented a paper "Review of Manitoba Health Services Commission" in which he recommends the amalgamation of Manitoba Health and the Manitoba Health Services Commission. His feeling was that the amalgamation would vastly improve the linkage of institutional and community-based and preventative health services and achieve a more effective system where the continuum of care is more integrated.

We realize that the notion of joining the two sections of Manitoba Health, Manitoba Health Services Commission and Community Health Services, has been around for some time and some efforts have been made in that direction, however, the separation and lack of coordination in the health delivery system is causing a major problem for the public requiring and receiving care.

While more integration of provincial direction is desirable, the local rural people want to have some say in how their health services are delivered. They seem to feel a lack of ownership of the system at present and feel they have no influence on the decisions that are being made that affect them.

Many of the institutions have gotten together to share services where one is not large enough to attract and maintain a full time service or to be able to attract a more highly qualified staff person. Many of these shared service arrangements seem to be working well however, at present, they are usually arrangements made because of necessity for survival and little planning takes place on a larger perspective.

Administrators of hospitals and care homes in a given region have been meeting together monthly for some years. Recently it would appear that Boards of Health Care Facilities have also recognized the need to get together to plan for the future. Community Health Services delivered through the present Regional Health Offices have also become involved in the planning as so many of the programs provided in the community hinge on institutional care and vice-versa.

In all 5 regions there have been some initial attempts to get together and air mutual concerns and to gain more cooperation among the local communities. These meetings have involved Board members, administrators, physicians and public health officials. The willingness to work together for a common goal seems to be present and needs to be encouraged.

Everyone realizes that all services cannot be provided in every small town, however better coordination and managing of the health care delivery system to meet more of the local needs with more local controls would be seen as an improvement.

Local physicians play a major role in the delivery of health care. Where the local physician refers his patient plays a significant part in whether that patient must travel hundreds of miles for service or whether it is only a few miles. Many sophisticated diagnostic services are not available close to home and specialists are few in rural Manitoba. However there are some cases where physicians will not refer a patient more locally for fear of losing that person as his patient and thus lose revenue. The present fee-for-service billing system fosters this practice. While we believe that physicians should be referring to the closest qualified doctor and facility and their keeping people at home, we are unable to offer a solution to the problem. The community itself must take some responsibility in that "bigger is not necessarily better" and it is not always necessary to see a "specialist". Trust in local physicians, and local and regional hospitals, must be maintained. Physicians must take an active role along with Boards and Administrators in the planning and delivery of health care services.

A model for regionalization has been provided by a number of presenters in our rural meetings. The structure as presented varied from informal joining together of providers, communities and consumers in a partnership to a formal structure of a regional governing structure including the same representatives, however, its function would be to review, plan, fund, monitor and evaluate all health care services within geographic boundaries. One stipulation that must be incorporated into any plan was the maintenance of the independent Boards for each Health District.

In 1972 the "White Paper on Health Policy" was produced in Manitoba. At that point in time the province was facing two major problems - 1) alarming increase in health costs, 2) medical and hospital care were not distributed according to the health needs of the population. In other words, there was inequality of delivery and access to health care. One solution proposed then was the development of District Boards for Health Care. These district boards would have the delegated responsibility of deciding how health resources were to be allocated for their district between hospitals, care homes, community services (including health and social services) and medical services. The idea was to integrate the health delivery systems at the local level under a local board.

The "District Health & Social Services Act" is the legislation that was enacted in 1975 to allow this to happen. In 1989 there were 44 such District Boards in Rural Manitoba. However, few have accepted any more responsibility than the hospital and personal care home services. There have been some Health Centres in existence for some 15 years, however, no evaluation process has been carried out to see if they are either cost-effective or service-effective.

New South Wales Australia, according to Raymond Harris, CHA, ADH, IAA, has been regionalized since 1968. There are nine regions. In one region there are 28 hospitals and personal care homes. He does not mention the community or social services. However, he does say that each region has its own Regional Office with a Regional Director and staff. Each facility has a Board of Directors who are responsible for the managing of the facility. Each region is allocated its own budget from Central Office and distributes it to the region. Harris says "Regionalization has improved communications and opened barriers isolating facilities from the so called bureaucracy". There appears to be a more active involvement in the delivery of health care and uniformity of standards, policies, etc., in the New South Wales model.

Ontario, in 1989, established some health strategies and goals. One of the initiatives is enhancing the role of the district health council. The council's responsibility has been to identify local needs, evaluate alternatives, establish priorities and plan a comprehensive health care program. There are 28 Councils presently. The Council is made up of representatives of consumers, providers and government. Discussions are presently underway to expand the role of these councils. Planning for human resources is one of the areas under discussion. Another initiative is in the area of Community Based Health Care - hoping to encourage alternates to institutional care and hopefully some integration of programs.

As has been stated earlier, we know that all services cannot be provided locally. We also are aware that there is a need to transfer very ill patients from one facility to another either for diagnostic tests or to receive care that cannot be provided locally. Many of these transfers must take place by ambulance. At present the local hospital pays for the ambulance trip if the patient is returned the same day. If the patient must stay at the receiving hospital to receive treatment not available at the local hospital the patient must pay for the ambulance. This does seem to place an unfair burden on the patient who must be transferred for care not available locally.

Ambulance services, including emergency care and transportation, are an integral part of the health delivery system. The present method of financing, partially by grant system to the municipalities and partially grant system to the various ambulance services, is awkward and time consuming and does not allow for the best use of the finances.

Some sharing of training, equipment and supplies with the local hospital is presently being carried out. Local authorities of the ambulance service may operate the service with little assistance from or relation to the local hospital Board while some are operated as a committee of the Board. In an attempt to integrate the health services provided locally one could see one Board being responsible for all health services including the ambulance service and thus determining the needs both vehicular and staffing needs.

The Task Force has deliberated long and hard regarding a proposal that would assure rural Manitobans more direct control over the health care they receive. The basic principal of equal access to quality health care must be strengthened. The various programs offered must be organized in such a fashion that the consumer will know how to access the service required and that programs will neither overlap or leve gaps for the consumer to all through.

Individual Health Boards have been expected to develop and deliver cost effective health care services to their community. The majority of Board members of rural Boards are municipal councillors or their appointees. Very little effort has been made to provide the Board members with any education as to their role and responsibilities in the Health Care System, however, much is expected of them by both their community and the government to provide direction in health care planning. While the majcrity of Board members are more than capable and willing to serve they lack the background knowledge in health care that would allow them to make an even more meaningful contribution.

The terms of reference of the Task Force include recommending on a "cost-effective means to expand the scope of health services in rural regional hospitals ...." however it must be realized that cost-effective can have several meanings. Cost-effective is often taken as being synonymous with cost saving or cost saving with an equal or better health outcome. But it may also mean "having an additional benefit with the cost". Little is known regarding the cost-effectiveness of providing care. It has been suggested that "there is probably no single most effective way (to provide health care) since this will depend on other services available, both in institutions and in the community, as well as on social, cultural, geographic and other factors" (Forbes, 1986).

The Task Force does not have the expertise to evaluate the cost our proposal for change to the delivery system. However, we believe that the proposed system would more adequately meet the needs of rural Manitobans.

We propose the amalgamation of the Community Health Services of Manitoba Health and the present Manitoba Health Services Commission which we describe as the Manitoba Institution and Community Health Services Commission. To achieve better coordination between programs the two major contributors must work closely together. As acute and long term care are both strongly affected by community care and vice versa the provincial programs that are developed and delivered must take into consideration both aspects.

The social programs presently delivered by the Rural Regional Manitoba Health Officers are under the direction of Manitoba Community Services ministry. It is proposed that these programs be transferred to Manitoba Health to more streamline the program control and reporting mechanisms of the employees.

At present Community Health Services reports to an Assistant Deputy Minister and through the Assistant Deputy Minister to the Deputy Minister while the Commission reports directly to the Minister of Health. The Commission with its Board brings the opportunity for a wider representation of public input into decision making. As it is our aim to allow for more input into the decision making it is desirable to retain the Commission Board Structure to encompass both the Institutional and the Community programs - see Appendix C.

There will, of necessity, remain the responsibility of M.I.C.H.S.C. to asure that standards of all health care programs are maintained for the people of Manitoba. Some provincial programs such as environmental health, communicable disease control, etc., may have provincial control, however, may be delivered at the local level under the jurisdiction of a local Board. At present the providers of all the community health programs are civil servants. As has been mentioned previously many of the Local Boards are already incorporated under the District Health and Social Services Act which allows them to undertake the services of public health, home care, etc. Assurance needs to be provided to the present Civil Servants that if they transfer to the Local Board that they will not lse the civil service benefits they have accrued. A mechansim for accomplisying this would have to be worked out.

While the amalgamation of Community Health Services and M.H.S.C. may accomplish better integration of and planning for health programs it does not bring the decision making any closer to rural Manitobans. We are therefore proposing the establishment of "Rural Regional Councils". Presently the Manitoba Health, Community Health Services, is divided into five Rural Regions with Regional Directors and Regional Offices remain and take on the responsibilities of the institutional and emergency health and ambulance services as well. However, it is also proposed that each Region be governed by a "Regional Council" that would have members from each of the local Boards, local physicians, and government appointees. Thus Regional decisions would be made by Regional people.

The Regional Council would have the authority and responsibility for all aspects of health care within that region, including program care, standards, evaluation, and budget allocation for acute care, long term care, ambulance services and community health and social services. They must assure adherence to provincial health policies and direction provided by the M.I.C.H.S.C. A member from each Regional Council would be elected to M.I.C.H.S.C. Board and thus provide Regional input into the provincial programs. Policies and possibly legislation would need to be developed by the provincial government in conjunction with the Regional Councils which would define the basis on which they would obtain funds and the method of their allocation.

To implement this proposal a strategic plan would have to be developed by an appropriate consultant who has expertise in this area.

The present local Boards would remain in control of their existing jurisdiction but may establish an integrated approach to health delivery either under the Health and Social Services District Act or by contract. They would thus take on more of the responsibilities of public health and appropriate social services and ambulance services. This could be accomplished by a number of Boards clustering together to assure viability of a program. See Organization Chart Appendix D.

The process of accomplishing a totally integrated system will need to proceed slowly. However, if the desire and willingness to take responsibility and ownership for the health care provided in the local areas is there, the mechanism should be in place to encourage it and allow it to happen.

Individual Health Boards have been expected to develop and delivery cost effective health care services to their communities. Much has been expected of them by both the community and the government to provide direction in health care planning. Even more will be expected of them in the future as they gain more input into some of the hard decisions that will have to be made at local, regional and provincial levels.

The majority of members of rural Boards are municipal councillors or their appointees. In numerous cases we know that there is some difficulty in obtaining people who are interested and willing to serve on the hospital Board. While it may be beneficial in some ways to have hospital board members elected in the same way as School Trustees, we were unable to come to any firm conclusion.

At present some educational opportunities are afforded Board members through M.H.O., however, because of home and business commitments, few are able to take advantage of them. It takes many Board members at least wo to three years to become familiar enough with the Health Care field to contribute to the Board by making will informed decisions and providing policy direction to their respective administrators. If we are to obtain the valuable input from the local people, we must have well informed dedicated Board members. The government and M.H.O. have a responsibility to ensure that the information needed by Board members is available to all Board members as early in their tenure as possible.

Loss of pay and out-of-pocket expenses are not attractions for the average Board member to attend educational programs. At minimum, out-of-pocket expenses and a reasonable stipend should be afforded the Board member for the contribution they make on behalf of the people in their community.

The local Board will inform an integral part of this Health Care Delivery structure and, without strong and knowledgeable local Board members, the proposed system will not succeed.

The Task Force therefore recommends:

I.1. That M.H.S.C. and Manitoba Health, Division of Community Services, should be amalgamated to achieve a more effective system where the continuum of care would be more integrated. Within this report the amalgamated entity will be referred to as the Manitoba Institutional and Community Health Services Commission - M.I.C.H.S.C.

I.2 This amalgamation should retain a Board structure which would report to the Minister of Health (see Organization Chart - Appendix C).

I.3 That the programs presently delivered by the Regional Health offices for the Department of Community Services i.e. child welfare and child day care, be transferred from the Department of Community Services to the Department of Health, Division of Community Services and subsequently to M.I.C.H.S.C. This would ensure that the Regional Director would have only one Department of Government to report to and would assist in further consolidating program delivery.

I.4 The present 5 Rural Health Regions mandate should be expanded to include responsibilities for organizing and delivering health care for the acute and long term institutions, ambulance, as well as those health and social services they presently deliver.

I.5 The local facility Boards should be maintained. They should assume the responsibilities for the ambulance services, community health and social services programs for their district where appropriate.

I.6 That an authority called the "Regional Council" be established within each of the regions to manage the health care programs within its mandate.

I.7 That the "Regional Council" should be made up of representatives from each of the Local Boards in the region; local physicians, and government appointment as necessary - see Appendix D.

I.8 That the Regional Council should have the authority and responsibility for all aspects of health care, including program planning, standards, evaluation, and budget allocation for acute care, long term care, ambulance services and community health and social services within the Region and to ensure access to those programs that cannot be delivered locally or within the region.

The Council should be accountable to their residents and to the M.I.C.H.S.C. for financial management and program delivery within the region.

I.9 That a member of each of the Regional Councils should be appointed to the M.I.C.H.S.C.

I.10 To ensure adequate funding for an integrated and comprehensive health program, legislation and policies must be developed by the provincial government as well as by Regional Councils which define the basis on which the Regional Council will obtain funds and decide on their allocation.

I.11 That all funding policies and program standards will be shared with the users in written form.

I.12 That to implement the amalgamation of M.H.S.C. and Community Health Services of Manitoba Health, as well as the development of Regional Councils, a strategic plan should be developed by appropriate consultants who have expertise on organization development, strategic planning, resource allocation, legislation, funding and administration, and that such a plan be put into effect.

I.13 That policies be developed to ensure that employees who now work for government or other health agencies and who would be transferred to local Boards retain their benefits and levels of compensation to the greatest degree possible.

I.14 That inter-facility ambulance transfers should become an insured service.

I.15 That consultation be undertaken by Manitoba Health and Manitoba Health Organizations Inc. for the development and implementation of a funded, portable, comprehensive, orientation and continuing education program (similar in substantiveness to that available to municipal councillors) for members of Regional Councils and Local Boards.

I.16 That Manitoba Health and the Manitoba Health Organizations, Inc., examine the benefits of an elected local facility Board similar to the School Trustee elections.

I.17 That all facility Board members should be paid out-of-pocket expenses and a reasonable stipend for their services.

II. INSTITUTIONS:

Many citizens of rural Manitoba are concerned with what they see as the erosion of health services in their local community. Professional staff, physicians, nurses, pharmacists, etc., are hard to recruit to the small towns. Fewer babies are being born in local hospitals and even fewer surgeries are being performed. The changes that have occurred in rural Manitoba include the following:

- shift of population from rural to urban
- age distribution within the population
- increased difficulty in attracting health care professionals to smaller communities
- increased dependence on business and personal services located in larger communities which makes travelling to such communities for medical services much more acceptable.
- increased dependence on medical specialists.
- limited scope of secondary services in larger community hospitals, due in part to the fact that patients are referred directly to Brandon or Winnipeg.
- increased possibility of litigation.

The facilities as they are today in rural Manitoba range in size and scope of service from the 6 bed unit to 104 bed hospital. The majority of the facilities have 1 or 2 physicians and an occupancy of 50-60%. The scope of service in many is limited to, and changes with, the current physician. Little, if any surgery is being carried out in the very small units and even fewer places are doing deliveries.

To this point in time many of the hospitals have coped with this by sharing of services to try and deliver the best possible care to their communities while still keeping the costs in control. Shared administration, financial services, group purchasing arrangements, shared pharmacists, dietitians, occupational and physio therapists, and regional laundry services are all being carried out between many of the facilities.

The need to define the role of these facilities becomes obvious when one considers that some of the smaller facilities may not be able to attract a physician in the future but some form of health care delivery still should take place in the existing facility. The larger facility's programs must therefore expand and be able to serve a wider area through more shared service arrangements. Within a region one could foresee the development of an integrated health care system that encompassed basic, primary, intermediary and secondary health care delivery areas, each with their own role within the region but each functioning in cooperation with the other.

By defining these areas it is considered that the following benefits may accrue:

- planning for construction, equipment, staffing and funding will be based on a regional program and take into consideration the ability to share services, not duplicate or overlap them.

- the ability to attract physicians to the smaller areas if a reasonable sharing of services and ability to practice in cooperation with a larger hospital where surgery or obstetrics is being practiced.

- by defining services in a secondary hospital it is hoped that more specialists will be attracted there as their area of practice would be enlarged to encompass the whole region. As well, the residents of that region will not by-pass the secondary hospital but would be able to receive the majority of their health care services there rather than in Winnipeg.

- better utilization of facilities (e.g. if a community loses their physician the hospital need not close - other programs could take over and provide the needed care on a shared basis with the neighbouring community).

- the development of standards that are reflective of the program parameters.

We have not attempted to classify the present facilities but rather to identify 4 levels of Health Service Delivery that we believe belong within a given region.

The Regional Councils, however, may wish to determine the designation of each of the facilities in their region to assist them in better program planning.

We have defined a program as a service which requires space, equipment, staff, funding and may require necessary support services.

The Task Force therefore recommends:

II.1. That the following description of "Health Service Delivery Areas" be considered by the Regional Councils as working definitions for the purposes of planning and programming within each Region.

Each Health Service Delivery area:

1. provides the program on-site (includes part time or shared service arrangements on a continual regular basis).

2. providers of service may come from somewhere else.

3. describes minimum requirements.

The following Health Service Delivery Areas be considered as working definitions within each Region:

i) Basic Health Service Delivery Area:

May include, but not be limited to:

- personal care in-patient services
- out-patient services
- medical services
- community health and social services
- ambulance services
- nursing services

ii) Primary Health Service Delivery Area:

May include, but not be limited to:

- in-patient acute and convalescent care
- in-patient personal care
- out-patient services
- emergency services
- surgical services limited to Schedule A of the College of Physicians and Surgeons (see Appendix - minor surgical procedures - no general anesthetic)
- low risk obstetrics
- medical services
- diagnostic services schedule
- general nursing services - 24 hour RN coverage
- pharmacy services
- ambulance service
- community health services - those services presently provided from Region
- social services - those services presently provided from Region

iii) Intermediate Health Services Delivery Area:

May include, but not be limited to:

- all of the above services plus
- surgery - Schedule B of the College of Physicians and Surgeons (see Appendix)
- anaesthesia
- obstetrics commensurate with Schedule B of the College of Physicians and Surgeons
- diagnostic services to include:
  - fluoroscopy
  - ultrasound
  - portable x-ray
  - blood gases
- therapy program, i.e. P.T. and O.T.
- dietary counselling/diabetic and B.P.
- pharmacy
- community health and social services programs.

iv) Secondary Health Service Delivery Area:

May include, but not be limited to:

- all of the above plus
- Medical Specialists in
- Pediatrics/Obstetrics
- Psychiatry
- Radiology
- Internal Medicine
- Surgery
- Anaesthesia
- Pathology
- Nursing services will be organized by specialty.
- Above specialty's will require support space, staff and equipment, where necessary.
- Rehabilitation program
- Dialysis
- Chemotherapy
- Diagnostic services - mammography, nuclear medicine, CAT scan.
- Educational programs in Medicine, Nursing, Therapies.
- 24-hour medical emergency room coverage.
- N.F.A. surgical program.
- full time ambulance attendants.
- all Community Health Service programs
- Social Service programs.
- Respirology.

III. EDUCATION:

Although we were not asked to review education per se it was brought to our attention by not only the rural presenters but by the professional educators that there seems to be barriers set up against the rural students receiving the same opportunity for professional education as their city counterparts.

Firstly, and probably most importantly, it is recognized that rural students must leave home, friends and family, to acquire any post secondary education. This may cause hardships for the family in terms of financial support for room, board and travel, and can have a very detrimental effect on the student as it was said many times the "culture shock" from rural to urban is great and some students have difficulty adapting quickly.

Compounding this we heard that accurate information regarding entrance requirements into some of the professions is not provided to the student so they can choose the necessary courses in their senior matriculation.

In reviewing the "Report of Manitoba's High School Review Panel 1988 - High School Education Challenges and Changes" they have said "The lack of articulation between high schools and post secondary institutions is the result of an absence of clear mandates and co-ordination." "Any lack of continuity and coordination between high schools and universities wastes educational funds and disappoints students. As well it is increasingly important that staffs in high schools be well informed of the admission requirements and objectives of universities and colleges when advising students on courses and career selection."

Small high schools, there are 80 of them in rural Manitoba, seem to be facing some similar problems to that of small hospitals. "Teachers in small high schools are frequently called upon to teach multi-grade classrooms and/or to teach subjects in which they have inadequate background" page 48 - Challenges and Changes. In some cases the minimum requirements to earn a high school diploma are being compromised with the inability of the school to offer all the required courses due to lack of sufficient students.

Manitoba Correspondence Branch offers some high school courses. Although the courses are chiefly print based at present, distance education and technology are being incorporated to increase effectiveness and efficiency of course development, instruction and delivery.

At an Invitational Meeting on Rural Physician Supply sponsored by the Manitoba Medical Association held in Portage in September of 1989, the members agreed that there was an inadequate representation of medical school applicants from rural areas. As mentioned earlier in this report research has shown that physicians with rural backgrounds are more likely than others to return to practice in rural areas. There seems to be no reason to believe that this same statement could not apply to any of the other professions - health related or otherwise. The group at the meeting in Portage felt that an awareness campaign targeting rural youth grades 7 - 12 and their parents needed to be developed to promote medicine as a career option.

There are some unique problems of education in each of the professions however there are also very similar challenges.

The Task Force therefore recommends:

III.1 That appropriate financial support in the form of bursaries or forgivable loans, be made available for students of health professions from rural Manitoba seeking post secondary education.

III.2 That high schools be well informed of the entrance requirements for the various health professions when advising students on course and career selection.

III.3 That the Department of Education establish as a priority the development of alternative programs and services to deliver high school education to rural areas to redress the present imbalance of opportunity. The development of distance education using a variety of mediums including video/audio broadcasting, audio teleconferencing and other emerging technologies should be pursued as soon as possible for all post secondary education.

III.4 That the Department of Education take steps to improve articulation among Universities, Colleges and High Schools to eliminate the gaps in programming.

III.5 That, beginning in grade 7, rural youth and their parents be made aware of the opportunities, the requirements and the rewards of a career in all health disciplines, through "career days", verbal presentations, and written materials. Each discipline would be responsible for its own campaign.

IV. RECRUITMENT AND RETENTION OF HEALTH PROFESSIONALS TO RURAL MANITOBA:

IV.1. Medical:

It is a well known fact that rural areas, not just rural Manitoba, are having difficulty recruiting and retaining an adequate supply of physicians. Many studies have taken place to try to discover what the barriers are and how to overcome them. Reid Lepnurm and Mark Trowell's research on rural physician satisfaction in an article in Forum - Fall/89 - "Satisfaction of Country Doctors" says that "possibly, physicians who were raised in rural areas are more satisfied with their practice because they are familiar with rural life and more aware of the demands of rural practice". They go on to say "family considerations and community factors such as spousal employment, good schools, etc., are as important as professional factors, (i.e. workload, after hours calls, no vacation replacement) and compensation in recruiting and retaining physicians". Rural Manitoba physicians presented the same view at our hearings.

At present, Canadian Medical graduates want more collegial support, regular working hours and modern, sophisticated diagnostic and treatment facilities with professional support staff.

In an article written by Dr. Robin Carter (Canadian Family Physician, Vol. 33: July 1987) he says "we train essentially generic family physicians and hope that society can beg, bribe or bully them into locating in our needy rural or remote areas". He feels that "what we need are programs in our medical schools effective in producing physicians who actually prefer rural life and practice". He goes on to say that this process involves:

"1. selection of right kind of student to train for rural practice;

2. the identification and teaching of the skills necessary to rural practice;

3. the teaching of these skills in a setting that will foster confidence in their performance and promote interest in location in rural practice."

Further "considerable research shows that a rural background increases the likelihood of rural practice location from 2 - 8 times".

We heard presentations from newly graduated family practice physicians who told us that they felt they were not prepared for the type of medicine they must practice in rural Manitoba. More skill training in some of the basic procedures was deemed necessary.

Research has shown that even a short exposure to rural practice prior to graduation has fostered some rural practice location. Minnesota recognized the same problem in 1971 and have operated a program whereby after an initial period of undergraduate medical education, students train for a year or more in clinics located in rural areas. To date, over 60% of program participants have located their practice in rural Minnesota. We understand that the Minnesota study looked at populations of 45,000 and under, however we feel that their experience could fit the Manitoba scene by extrapolating the population numbers. As the majority of the physicians are family physicians it seems only appropriate that the Department of Family Medicine would be responsible for establishing and carrying out this program in conjunction with rural community hospitals.

At present in Manitoba medical students (years 1, 2, 3 and 4) may choose to go to rural Manitoba during their medical school training. There is financial support for this program through the Standing Committee on Medical Manpower. However, there does not seem to be a great deal of support by Hospital Boards or communities for these students. In fact it is quite conceivable that the Hospital Board is not aware that they are there or what they are there for. The Hospital Board and physicians may not recognize that this is an opportunity for them to sell themselves to this student so that he/she may return to practice in rural Manitoba.

Dr. G. Beazley, Head of Family Medicine, told us that there is a program being set up for Residents to have a rotation in the Dauphin area hospitals. It is proposed to have 6 residents carry this out initially. While some of these programs for "exposure" to rural Manitoba have been going on for some time it is unclear what benefit they are providing in the recruitment and retention of physicians for rural Manitoba.

The Task Force therefore recommends:

IV.1-1 **That the Faculty of Medicine of the University of Manitoba develop a selection criteria for admission to Medicine that would assist in the recruitment of an adequate number of graduates to practice in Rural Manitoba. That if this is unsuccessful within two years a specific number of seats may have to be set aside for rural students.**

IV.1-2 **That the University of Manitoba, through the Department of Family Medicine, research the skill as well as educational requirements, and develop a program specifically for rural family practice within the next two years.**

IV.1-3 **That rural Manitoba hospitals and rural physicians that would qualify according to the criteria developed by the Department of Family Medicine, provide at least one of the years of residency training on site, similar to the Minnesota program. And further, that those physicians providing the training be compensated over and above their fee-for-service or existing salary.**

IV.1-4 **That community hospital Boards and communities work with their local physician to encourage the students who are on an "exposure" session to return to rural Manitoba. Provision of living accommodation and/or transportation by the community would be an asset.**

Standing Committee on Medical Manpower (S.C.O.M.M.):

The Standing Committee on Medical Manpower (S.C.O.M.M.) was established in 1979 "for the purpose of review, analysis, evaluation and recommendations with respect to all matters bearing on the supply, category of practice and geographic distribution of physicians in Manitoba" (1988-89 MHSC Annual Report).

The major problems that this committee has dealt with is recruitment of physicians for rural Manitoba, both in general practice and specialty areas.

Some Monetary Incentive programs that have been established to encourage physicians to practice in rural Manitoba include:

Summer Work Experience (1st & 2nd Year Students) - to gain exposure to rural life;

Loans to 3rd & 4th Year Medical Students - forgivable if they undertake to practice in a medically underserviced area;

Community Medicine Rotation - 4th Year Medical Students take 6 - 8 week clerkship with some remuneration if taken in rural Manitoba;

Rural Residency Program for Practicing Physicians - Post-graduate specialty training courses of 1 - 6 months with funding directly from MHSC which will hopefully assist them in a rural practice, i.e. anaesthesia;

Family Practice Residency Program - Rural Rotation - transportation and accommodation are paid;

Incentive Grants - to physicians commencing practice in designated medically underserviced areas (may provide a guaranteed net income or an income tax free incentive grant payable over a four year period).

Although these programs have been in place for some years they have met with limited success in being able to either recruit or retain sufficient physicians for rural Manitoba.

In an article by John Horne (Forum - Summer 1989) entitled Health Care in Rural Manitoba: Resources and Related Issues of Access, he states that "in resource terms, the rural system combines a generous supply of hospital beds with a problematically low number of primary physicians. However, the irony of the physician shortage in rural communities is that numerically, it could be solved by transferring as few as 20 to 30 G.P.'s from Winnipeg where there is agreeably an oversupply."

We heard in some of the presentations from rural Manitoba doctors and others that the quota system of rationing medical numbers in Winnipeg and forcing physicians to practice in rural Manitoba should be imposed. However, this was already tried by British Columbia and adjudged by the Courts to be illegal.

Several organizations, including S.C.O.M.M., University of Manitoba, Manitoba Medical Association, the College of Physicians and Surgeons of Manitoba, Manitoba Health Organizations, Inc., and Policy Planning Secretariat of Manitoba Health, have been working on some aspect of the medical manpower shortage. Resources are also being used in a similar fashion to recruit other needed health professionals who have either complementary or overlap services with the physician. The Task Force feels that if the time and energy that is presently being expended by each of these groups could be coordinated and undertaken by one group with adequate resources and power, the problem could be better resolved.

The Task Force therefore recommends:

IV.1-5 **That the Standing Committee on Medical Manpower be reconstituted as a Health Professional Manpower Council with the legislative authority to carry out the various actions necessary to ensure an adequate supply and distribution of health care professionals including, but not limited to, physicians, nurses and rehabilitation therapists. And further that this Council report to the Ministers of Health and Education.**

IV.1-6 **That the physical resources and supporting staff required to carry out this mandate be made available.**

IV.1-7 **That, because of the necessity to liaise closely with the Universities, College of Physicians and Surgeons and the Department of Immigration, the physical facilities be located in Winnipeg.**

IV.1-8 **That the many "exposure" programs (i.e. years 1, 2, 3 & 4) now being offered through S.C.O.M.M., be evaluated with a view to either consolidating or eliminating them.**

IV.1-9 **That living arrangements and transportation for the Family Practice Residents while on rural rotation not be an expense to the Resident.**

Licensure:

With the number of communities looking for and unable to obtain Canadian or, in particular, Manitoba physicians they have had to turn to recruitment from other countries. The Standing Committee on Medical Manpower in conjunction with the College of Physicians and Surgeons and the Department of Immigration have been able to successfully recruit many foreign grads to work in rural Manitoba. At present the question of licensure for these graduates has come under some criticism and scrutiny. Currently, to practice in Manitoba, they must pass the Medical Council of Canada Evaluating Examination (MCCEE) however, the Minister may waive the exam for a period of six months. This enables the recruitment of physicians from other countries to provide "locum tenens" service.

There is at present a thrust towards requiring them to write the LMCC prior to practice in Manitoba. This would certainly discourage and possibly dry up this foreign graduate resource. Until such time as we can rely on our own schools or our own Manitoba physicians to locate in rural Manitoba this requirement could prove to be disastrous.

The Task Force therefore recommends:

IV.1-10 That the Minister continue to provide a waiver of the MCCEE for six months when appropriate for locum tenens.

IV.1-11 That the College of Physicians and Surgeons of Manitoba take into consideration the possible ramifications to the supply of physicians for Rural Manitoba prior to making any decision regarding the attaining of an LMCC as the only entry into practice in Manitoba.

Solo Practice:

We heard many times and have learned from our research how difficult it is to recruit physicians to rural areas. The problem of the solo practice significantly augments the problems. While we now have in Manitoba many physicians practicing in a solo practice, we are led to believe that we cannot expect this to continue. "Canadian-trained physicians will no longer be opting for a solo practice ..." (Lepnurm & Trowell 1989). Collegial support is not readily available and the working day is 24 hours. Even relief for vacation is difficult if not impossible to obtain.

One must have a great deal of respect for the physicians who have and continue to provide their communities with health care in a solo practice and continue to do so.

However, we must also look at the problem we are facing of not being able to recruit and retain physicians to not only the solo practice but to any practice in rural Manitoba.

Elizabeth Sweatman, a Master's of City Planning Thesis Student, presented a paper to the Standing Committee on Medical Manpower in October 1989. She had asked hospital and community people if they felt they had a role in the recruitment and retention of physicians to their community. The answer in every case was yes, however, immediately the anger and frustration, resentment and insecurities came out.

We heard it again and again at our "town hall" meetings how angry the people were at being told what to do and how to do it by Winnipeg. "Perimeteritis" they called it in one instance. They cannot understand why physicians or other professionals of similar ilk would not want to locate to their community. In Sweatman's research she says "they (community hospital group) are angry that doctors receive an education that is partially subsidized by tax dollars, and refuse to practice where they are needed. They are angry that the doctors they do have, control the process by discouraging potential candidates because they do not want to share the billing market. The people have virtually no say in the ways and means of medical care delivery in their own town but they suffer from the resulting underservice."

In many instances, either because of economics or lack of ability to recruit, hospitals have had to share some of their professional staff. Communities and physicians have worked together to secure ultrasound services for the area, shared pharmacy services, shared public health services, shared administration and the list goes on. The medical profession may have to look at some type of shared arrangements. Many physicians now provide services to two or three clinics other than their place of residence or hospital. Three or four physicians may be able to get together from neighbouring towns and share on call duties, share vacation replacement, and share their knowledge, expertise and provide support to each other.

For this to happen however, the physician must want it and the public must be totally supportive of the arrangements. Public education of what constitutes an emergency, much more judicious use of the emergency room of the local hospital, and understanding that the physicians deserve a life of their own if you want them to stay in your community, is necessary.

There also must be in place a means of handling those true "emergencies" when they do arise if a physician is not available at your hospital. Ambulance services certainly play a role in the stabilization and transport of the sick and injured and must be available when needed. Nurses may require more skills in assessment and the ability to treat an "emergency" upon a doctor's telephone order.

The Task Force therefore recommends:

IV.1-12 That every effort be made by M.I.C.H.S.C. , hospital boards and communities to allow for shared arrangements between physicians of neighbouring towns.

IV.1-13 That hospital Boards further encourage sharing of physicians by granting of admitting privileges to the neighbouring physicians when deemed appropriate.

IV.1-14 That Hospital Boards and physicians initiate a public education campaign within their communities to address the proper utilization of emergency services including use of emergency room and the on-call physician and to keep them informed of available shared medical services when appropriate.

<u>Monetary Issues:</u>

While the first part of the section dealing with recruitment and retention of physicians in rural Manitoba did not mention remuneration it is well known that a higher remuneration while not the sole influence will certainly have a significant influence in keeping physicians in rural Manitoba.

There have been and are in place some different arrangements for payment to physicians. The most common is fee-for-service. At present there is a differential between Urban and Rural physicians of 5%, Urban and Brandon of 2.5% and Urban and north of 53rd of 10%. While this may not appear to have a significant impact on recruiting physicians to rural Manitoba, it may play a role in retaining physicians there, once they are established. Along with this arrangement other incentives such as supplying office space, equipment, and adequate housing could be added to entice them to come to rural Manitoba.

A guaranteed net income arrangement is offered by some Boards where the population served is low or he/she is just starting his/her practice, but wishes to stay on a fee-for-service basis as opposed to salary. This will assure the physician of a minimum income.

Yet another method of payment is salary. It would appear that this arrangement is becoming more and more popular for rural Manitoba. In 1980 there were 12 physicians on salary whereas in 1989 there were approximately 45. The "White Paper" of 1972 advocated District Boards with responsibilities for hospitals, outreach health care services, and physicians on salary. We heard from one District Health Centre that physicians on salary seems to have worked well for them over the past 15 years. No attempt has been made to see if it is cost-effective but they at least do not appear to have had problems recruiting and retaining physicians. Some of the other areas that have had this arrangement have, however, not been so fortunate.

Salaried physicians are provided with offices, equipment, staff and usually generous educational and vacation leave and other benefits. Working conditions are with colleagues who share on call duties and support through consultation. Other health professionals in the district seemed to benefit from them as well, as the physician seemed to have more time to participate in community health programs, health education and planning.

Specialists are rare in rural Manitoba however arrangements have been made by some Boards to bring in specialists for consultations and teaching on a regular basis. This does three things for the community 1) it supplies them with direct access to the specialist without travelling to Winnipeg, 2) develops a collegial support system for the rural physician, and 3) helps to curtail some of the financial drain on the local community that seems to happen when people are required to travel to the bigger centres to meet their health care needs.

At this point in time there are very few specialists willing to leave their office practice in Winnipeg and travel out to the country. There are no real incentives in the system to encourage this practice. Travel costs and remuneration for time lost at the office are not recovered unless the Board has made a conscious effort and is willing to pay for these things.

The itinerant surgical program falls into this category as well. This program has been approved by the College of Physicians and Surgeons of Manitoba as providing safe surgical care, however, each hospital wishing to take part in the program must be approved individually. The requirements they look for include adequate anaesthetics, diagnostics, O.R. and recovery facilities as well as nursing staff. While this may seem costly if surgery is only performed every other week, it does provide advantages to the area receiving the service such as reduced need for transfers to Winnipeg and maintenance of skill levels of both physicians and nurses particularly in the case of emergency care requiring intubation and/or minor surgical intervention.

Every hospital must have by-laws and part of the by-laws are the medical staff by-laws. A Chief of Staff is appointed and there are certain expectations of him/her. Over the past 5 - 10 years more and more administrative duties are being foisted onto the Chief of Staff, i.e. Quality assurance, committee memberships such as Infection Control, Joint Conference, etc. This naturally takes time and commitment to high standards of care by our medical staff. The Task Force feels that if we want to gain and maintain good working relationships with the physicians, no matter which remuneration process the physician has, this work should be recognized monetarily.

Boards and the public must know and understand the expectations of their physician and the physician must know and understand the expectations of the community. The objectives of the physicians and the boards must be the same to either plan for or carry out any changes to the delivery of health care.

The Task Force therefore recommends:

IV.1-16 That the differential between Urban and Rural physician pay schedules be maintained and that an increase in the differential be considered.

IV.1-17 That the Hospital Board take a more active participating role with current medical staff in determining the method of payment for the physicians in their community, i.e. fee-for-service, salaried physicians, etc.

IV.1-18 That a mix of methods of payment, i.e. fee-for-service, salary, etc., should be accommodated within the same medical community.

IV.1-19 That the Hospital Board, Medical Staff and M.I.C.H.S.C. encourage arrangements for specialists to provide some services to local communities.

IV.1-20 That the itinerant surgical programs be encouraged to continue with the College of Physicians and Surgeons' approval.

IV.1-21 That an honorarium and/or transportation and out of pocket expenses be paid for specialist or itinerant surgeons who take part in these programs.

IV.1-22 That the Chiefs of Staff of all rural hospitals be reasonably compensated for the work carried out in that role.

IV.2 Nursing:

In 1966 a report on the "Supply of Nurses" was prepared for the Minister of Health. In 1977 a "Joint Ministerial Task Force" made a report to the Minister of Health on Nursing Education. In 1985 the "Manitoba Nursing Review Committee" was commissioned by the Minister of Health to review the status of L.P.N.'s in particular and nursing education in general. All three reports contain in them some of the same observations that we heard from the nursing sector in 1990.

There is confusion by many about the role of the B.N., R.N., R.P.N., L.P.N. and nurse practitioner. Educational preparation appears to be changing as we heard from the University, a hospital based school of nursing and the L.P.N. association. At this point there does not seem to be a coordinated effort to determine either what is needed or how to provide it for the overall field of nursing. This was identified as a major problem in all three prior reports and recommendations made, however, the scene does not seem to have changed appreciably.

The rural nurse must respond to a wide variety of problems within his/her practice and is obliged to assume patient-care responsibility or supervisory responsibilities for which he/she is not prepared. The current skill level of the new graduate is not adequate for the degree of responsibility placed on them in small hospitals.

M.H.S.C. recognizes very little orientation time for nurses, nor do many of the smaller hospitals have the resources to teach the new nurse skills that she may not have learned during the formal education period.

Rural nurses are at a disadvantage when it comes to attaining further nursing education. For an R.N. to upgrade to the B.N. level she/he is forced to leave home and travel to either Brandon or Winnipeg. Distance Education is minimal and it appears difficult if not impossible, to take the necessary courses to upgrade from an R.N. to B.N. level in rural areas. Again the cost associated with upgrading for the rural nurse includes not only the tuition but the travel, board and room, as well as possibly being away from family.

The Task Force therefore recommends:

IV.2-1 That, a Nursing Council be established which would, with the cooperation of the Universities, Colleges and Hospital Schools of Nursing, correlate and coordinate the various nursing education programs.

IV.2-2 That the Nursing Council be made up of representatives appointed by the M.A.R.N., M.A.L.P.N., and M.A.R.P.N., the Universities, the Colleges, the Hospital Schools of Nursing, the facilities, community health and the public.

IV.2-3. That the Nursing Council make recommendations to the Ministers of Health and Education with regard to the coordination of nursing education programs and a plan to implement same as soon as possible.

IV.2-4 That a specialty course of Rural Nursing should be developed which would meet the needs of rural nursing.

IV.2-5 That until the Rural Nursing Specialty course is developed, the funding authority recognize an acceptable orientation period for the new graduate nurse as determined by the employer.

IV.2-6 That a distance education program for nurses wishing to attain the Baccalaureate degree in Nursing be made available from the University Faculty of Nursing as soon as possible.

IV.3 Therapy Services: Including O.T., P.T., Audiology, Speech Pathology

Changing trends in the health care of Manitobans, including reduced length of hospital stay, additional extended care beds, and increase longevity have increased the demand for both physio and occupational therapy. In February 1989 the Manitoba Branch of the Canadian Physiotherapy Association presented a brief to the Minister of Health and Education outlining their concerns regarding the critical shortage of physiotherapists in Manitoba. In April of 1989 The Manitoba Society of Occupational Therapists also presented a paper outlining many of the same concerns. In December 1988, Dr. Wm. MacDiarmid was engaged by the Department of Health to undertake a review of rehabilitative services in Manitoba. His report and extensive review was presented in July, 1989. In his report he outlines many of the problems identified in the recruitment of physio and occupational therapists in rural Manitoba. As is the case with both physicians and nurses there are barriers for rural students to take these courses.

While a considerable portion of the teaching, for logistic reasons, must be carried out in Winnipeg hospitals, some can and should take place in rural areas. The majority of both O.T.'s and P.T.'s are located in Winnipeg. Many rural users must travel to Winnipeg for treatments. Some therapists based in Winnipeg provide travelling clinic resources to rural users, but often with a large component of total professional time spent in travel.

While Dr. MacDiarmid in his report recommends that O.T. and P.T. class size be increased, he also recommends that "7.1.3 - Financial support by M.H.S.C. for all students should be enhanced, particularly for rural students and those who undertake to assume practice in rural locations".

We also heard problems associated with the overall organization and administration of the rehabilitation services. Lack of local control or ownership of the program presents a particular problem for rural Manitoba. "Simplification and consolidation are the only feasible and affordable measures, particularly for rural Manitoba" - MacDiarmid says. Lack of agreement by M.H.S.C. with the facilities on space and equipment required for a facility when in a construction phase were also mentioned as barriers to providing the program in the local community.

Recently the first training program for physio-aides trained in Geriatric care graduated at Middlechurch Home. It is too early to say how this program will turn out but it would seem appropriate that "aide" category of training may assist, particularly the elderly, in the provision of service in a time when the Province and indeed the country is short of physio and occupational therapists.

Language/Speech pathology and audiology programs are limited in rural Manitoba. We heard from groups that lack of coordination of some of these programs is causing a problem particularly for pre-school children.

The Task Force therefore recommends:

IV.3-1 **That, when appropriate arrangements can be made, some of the teaching or practicum of P.T. and O.T. students be spent in approved rural hospitals.**

IV.3-2 **That rural students receive enhanced financial support when they undertake to assume practice in rural Manitoba.**

IV.3-3 **Dr. MacDiarmid's recommendation 6.3 is supported and reiterated here: "Simplification and consolidation are the only feasibly and affordable measures, particularly for rural Manitoba. Local control is equally practical and desirable. All presently diversified activities should be collected under one locally based administrative body. All therapists should be hired and based (i.e. resident) locally, except for highly specialized programs and extremely remote areas.".**

IV.3-4 **That space and equipment requirements to run a rehabilitation program be provided for in new or expanded facilities.**

IV.3-5 **That following a positive evaluation of the geriatric rehabilitation aide program that further "aide" programs of this nature be developed and provided.**

IV.3-6 **That Regional audiology, speech and language pathology programs be assured.**

V. SUMMATION:

The Task Force addressed only a few of the health care professional groups that Rural Manitoba is experiencing difficulty in recruiting. Social workers, dietitians, pharmacists, and respiratory technicians are some of the other areas of concern. However, it was felt that many of the same problems in recruitment and retention of professionals in rural Manitoba are experienced in all professional groups.

We also must acknowledge that some of the recommendations we have made, we understand, are already being carried out, particularly in the area of recruitment of physicians by the Standing Committee on Medical Manpower. By reiterating them here is may give some assistance to them to continue.

The Task Force realizes that some major changes to the organization and delivery system of health care have been proposed. However, the problem of the exodus of people from rural to urban and the unwillingness on the part of the professionals to locate in rural Manitoba must be recognized and addressed, as well as the present lack of meaningful organization and structure for the delivery of health care to rural Manitoba.

It is our sincere hope that our recommendations will be given due consideration and that some changes will be forthcoming in the near future.

APPENDIX A

MEETINGS:

October 24, 1989	Dr. George Dow	Physician at Killarney representing the Standing Committee on Medical Manpower
	Marcel Painchaud	Secretary to the Standing Committee on Medical Manpower
November 14, 1989	Phyllis McDonald	Standards Officer, Urban - M.H.S.C.
	Wes Reimer	Standards Officer, Rural - M.H.S.C.
	John Robson	Director, Rural Facilities Division - M.H.S.C.
	Ann Hrenchuk	Standards Officer - M.H.S.C.
	Kay Thomson	Director, Long Term Care Programs Division - M.H.S.C.
	Ken Knaggs	Manager, Emergency Health & Ambulance Services - M.H.S.C.
December 2, 1989	Carmel Olson	C.E.O. Deloraine/ Melita - representing W.I.S.H.
December 12, 1989	John Robson	Director, Rural Facilities Division - M.H.S.C.
	Dr. R. Cooke	Medical Advisor - M.H.S.C.
	Dr. Hinch	College of Physicians & Surgeons of Manitoba
	Dr. Ken Brown	Registrar, College of Physicians & Surgeons of Manitoba
	Dr. Gary Beazley	University of Manitoba, Faculty of Medicine

APPENDIX A
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	Dr. Nick Antonisen	University of Manitoba, Dean of Medicine
January 22, 1990	Clay Hutchinson	Regional Director, Brandon
	Shirley Jo Paine	Director of Nursing, Brandon School of Nursing
	Ross Sheardown	C.E.O. Hamiota Health Centre
	Dr. Ed Hudson	Physician - Hamiota Health Centre
February 19, 1990	Susan Derk	C.E.O. - Manitoba Association of Registered Nurses
March 13, 1990	Dr. Janice Larsen	University of Manitoba, Dean of School of Nursing
	David Driedger	Masters of Nursing Student
	Verna Holgate	C.E.O. - Manitoba Association of Licensed Practical Nurses
May 4, 1990	John Ross	Executive Director, Manitoba Community Health Services

APPENDIX B

VERBAL PRESENTATIONS:

February 1, 1990 - Carman Town Hall:

H. Neufeld & Steedsman	Winkler/Morden Hospital Boards
Dr. P. Doyle	Ste. Anne Hospital
Gary Mattin	Portage la Prairie Hospital Administrator
Marilyn Skubovius	Morden Citizen
Claudette Lahaie	Notre Dame - Assistant Administrator
Brian McGill	Carman - Board Chairman
Robert McKenzie	Carman - Mayor
Peter Elias	Altona Hospital - Administrator
Joe Legault	Cartier Municipality - Reeve

February 8, 1990 - Souris Town Hall:

M. Hicks	Souris Health Board
Sheldon Lanchbery	Deloraine/Melita Board
Drs. Abel	Wawanesa
Nancy Everard	Wawanesa
Helen Levi	Glenboro
Phil Crowe	Baldur
Shirley Brown	Wawanesa
Glen Worthington	Rivers Hospital - Administrator
Dr. Cooper	Souris - Surgeon
Dr. Cram	Souris - Physician

February 15, 1990 - Shoal Lake - Buffalo Plains Inn:

Mr. Urbanoski	Shoal Lake Administrator
Ted Bartlett	Birtle Administrator
Mrs. Laura Horn	Citizen of Souris
Ray Blayock	Russell Board Chairman
Marge Will	Secretary-Treasurer, Town of Elkhorn
Avis Stitt	Rossburn C.E.O.
Larry Budzinski	Child Development Team Member - Birdtail School Division
Verla Anseeuw	Women for Action (Birtle)
Clare Tyre	MacGregor Citizen
Aileen Smith	PHN - Child Development Team

February 22, 1990 - Dauphin - Ukrainian Catholic Hall:

Sr. Jean Zemliak	St. Paul's Home Administrator
Gordon Shaver	Swan River Chairman
Art Millette	Ste. Rose Hospital
Harold Zabowski	Tri-Lake Health Centre - Killarney
Steve Gingera	McCreary Board Chairman
Mr. Koszman	McCreary Hospital - Administrator
Martin Bidzinski	Dauphin - Mayor
W. H. Harris	Dauphin Executive Director
R. M. Forbes	Dauphin Chairman
Donna Decker	Dauphin Chemotherapy
Lenore Fenton/Earl Smith	Russell Concerned Citizens
Don Burr	Winnipegosis C.E.O.
Dr. Ritchie	Dauphin - Physician

March 1, 1990 - Teulon - Centennial Hall:

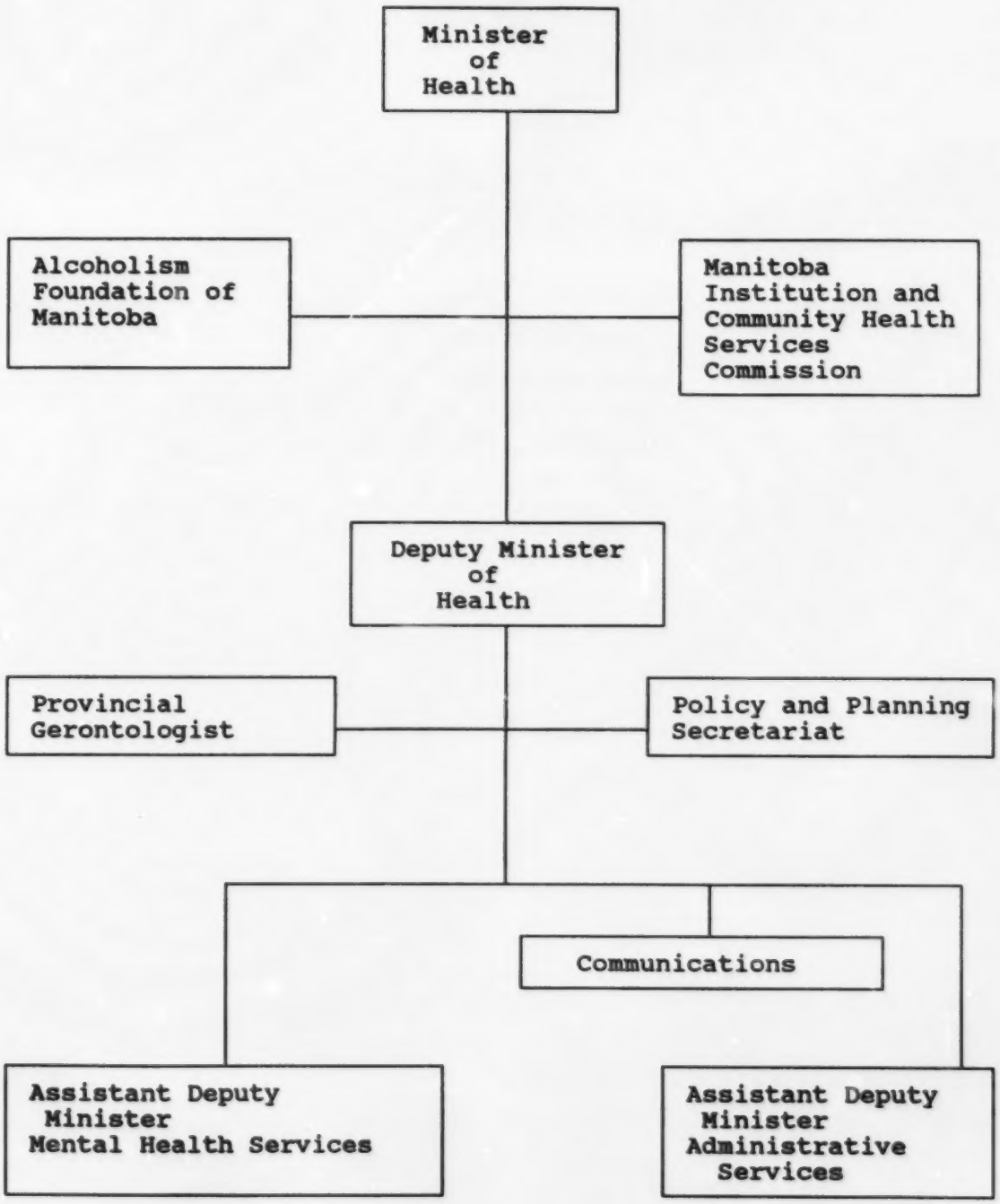
Debbie Bennett	Teulon Health Centre
Lillian Olson/Judy McKinnon	Gimli Health Promotion Committee
Irwin Corobow	Community Therapy Services
John Gow	Interlake Regional Director
Zeth Wiesenthal	Regional Mental Health
Brian Kellough	Canadian Mental Health Assoc.
Jim Shilliday	Village of Woodlands
Isabel Rourke/Ed Bergen	Stonewall Hospital
Joe Smolinski	Selkirk Hospital Board Chairman
Olaf Hardy	NUB Networking Group

March 8, 1990 - Steinbach - Multipurpose Room, Bethesda P.C.H.:

Bernie Loeppky	Eden Mental Health Centre
André Remillard	St. Pierre Jolys
K. P. Aujlay	Vita District Health Centre
Bill Patmore	Steinbach Hospital
George Neufeld	Resthaven Nursing Home
Dr. K. Bullock Priese	Steinbach
Anne Friesen	Senior PHN Steinbach
Gerhardt Suss	Regional Director Eastman
Val MacKay	Pine Falls C.E.O.
Peter Cliche	Pinawa C.E.O.
Murray Graham	Beausejour C.E.O.
Theresa Conroy	Whitemouth C.E.O.
Dr. Curtis Krahn	Steinbach

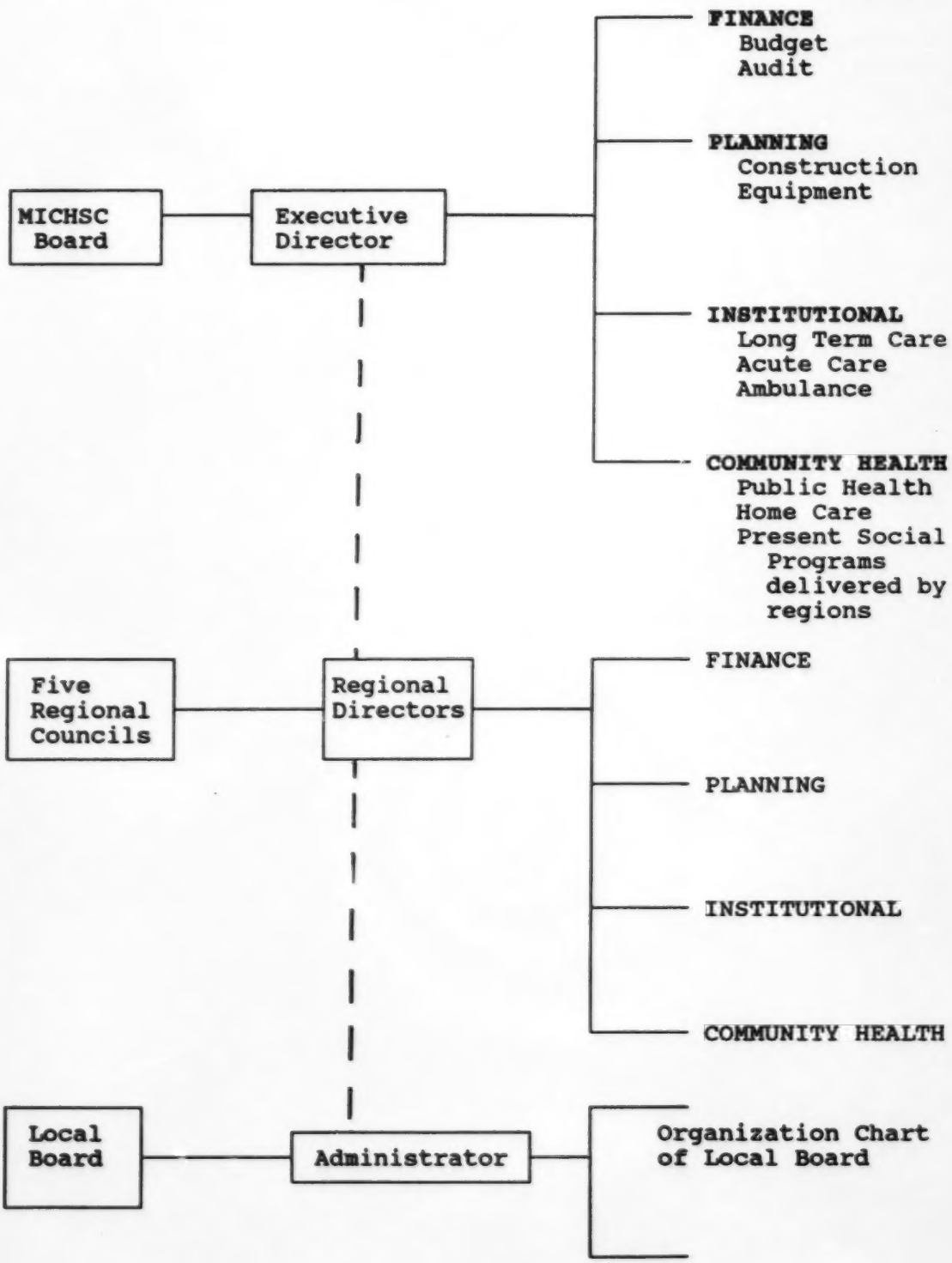
APPENDIX C

ORGANIZATION CHART


Minister of Health
Alcoholism Foundation of Manitoba
Manitoba Institution and Community Health Services Commission
Deputy Minister of Health
Provincial Gerontologist
Policy and Planning Secretariat
Communications
Assistant Deputy Minister Mental Health Services
Assistant Deputy Minister Administrative Services

APPENDIX D

ORGANIZATION CHART



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(CONT'D)

- Evaluation of a Selective Medical School sions Policy to Increase the Number of Family Physicians ıral and Underserviced Areas - Rabinowitz - The New England Journal of Medicine - 1983

- Presentation to the Standing Committee on Medical Manpower - Elizabeth Sweatman - 1989

- Satisfaction of Country Doctors - Lepnurm and Trowell - Forum - 1989

- Physician Redistribution: A Worldwide Medical Problem - J. E. Verbey

- Medical School Admissions, Specialty Selection & Distribution of Physicians - Cullison, Reid, and Calwill - JAMA - 1976

- Training for Rural Practice: What's Needed - Robin Carter - Canadian Family Physician - 1987

- Proceedings of the Invitational Meeting on Rural Physician Supply sponsored by MMA.

- Review of Rehabilitation Services in Manitoba - Dr. Wm. MacDiarmid - 1989

- Shortage of Physiotherapists getting worse - Manitoba Branch Canadian Physiotherapy Association - 1989

- Manitoba Society of Occupational Therapists Position Paper on "Manpower Issues" - 1989

- Handbook for District of Regional Integrated Health System Development - W. K. Kellogg Foundation

SCHEDULE A - BASIC MARCH 1990

This form is intended to be used in the allocation of elective procedural privileges. In emergency situations, individual clinical judgment must prevail.

CREDENTIALS: Clinical Clerkship plus twelve months internship required for general licensure
* Those holding obstetrical privileges must be prepared to handle attendant complications, e.g. cervical tear, tear into rectum, manual removal of retained placenta.

ANESTHESIA
___laryngoscopy direct and tracheal intubation
___local block (digital)
___local anesthetic infiltration

BREAST

___aspirate cyst
___needle biopsy
___abscess drainage

CARDIOVASCULAR

___arterial blood gases
___venous lines
___venous cut down
___simple vein ligation, local concurrent sclerotherapy

CLINICAL

___biopsy skin, subcutaneous tissue, mucous membrane
___incision and drainage abscess, hematoma, carbuncle, furuncle, paronychia, pilonidal abscess
___foreign body removal (including simple cornea)
___laceration repair (simple)
___burns: 1°, 2°, less than 10%
___excision skin lesion with closure or subcutaneous tumor with closure
___nail avulsion and matrix excision
___split thickness skin graft under 3 sq cm
___phlebotomy

DIGESTIVE TRACT

___esophageal dilatation (Bougie - not initial)
___sigmoidoscopy, anoscopy, proctoscopy
___incision and drainage, external hemorrhoid
___incision and drainage, perirectal abscess
condylomatous excision or cautery
___excision anal papilla, anal skin tags
___anal dilatation
___paracentesis

EYES, EARS, NOSE & THROAT

___epistaxis control with packing

GYNECOLOGY

___excise tags or condylomata, vulva
___incision and drainage abscess, vulva
___punch biopsy of cervix
___dilatation of urethra

PHYSICIAN:

FACILITY:

CHIEF OF STAFF SIGNATURE:

HEMATOLOGIC

___bone marrow aspiration and biopsy
___lumbar puncture

Endoscopy (excluding biopsy and removal of foreign body):
___otoscopy
___rhinoscopy
___proctoscopy
___sigmoidoscopy
___vaginoscopy
___anoscopy
___indirect laryngoscopy

OBSTETRICS *

___NST
___uncomplicated cephalic deliveries
___episiotomy

ORTHOPAEDIC

___undisplaced fractures not requiring reduction and not better treated with internal fixation, e.g. fracture of the clavicle, humerus, radius (single), ulna (single), carpal bones, metacarpal or phalangeal fractures, nasal fractures
___application of cast
___dislocations temporal mandibular joint, clavicle, shoulder, elbow, finger, toes
___aspirations finger, toe (traumatic)
___aspiration or injection of joints, bursa or tendon sheaths

RESPIRATORY

___thoracentesis
___chest tube insertion

RETICULOENDOTHELIAL

___lymph nodes abscess simple drainage

URINARY TRACT AND MALE GENITALIA

___dorsal slit procedure
___circumcision neonate
___bladder aspiration
___hydrocele aspiration
___suprapubic stab catheterization

GENERAL

___surgical assistance: sterile technique, skin preparation and draping, instrument handling, closure techniques

___OTHER (indicate if listed on reverse

COLLEGE APPROVAL:

SCHEDULE B - ADVANCED

This form is intended to be used in the allocation of elective procedural privileges. In emergency situations, individual clinical judgment must prevail.

CREDENTIALS: Basic eligibility for surgical privileges plus documented experience with the privileges requested in a training program approved by the College. Anaesthesia (including ABA III) & Obstetrics: A minimum of six months formal training.

ANAESTHESIA (documentation to accompany application)

___ Child & Adult except:
___ paediatric > 24 months - 3 years
___ </= 24 months

BURNS

___ any other burn except:
___ 2° > 5% except
___ 2° > 10% if < 2 years or > 65; other systemic disease associated trauma or GI or respiratory burn
___ 2° burns of the hand, foot or perineum
___ escarotomy

GENERAL SURGERY

___ anal fissure
___ haemorrhoidectomy
___ hernia: inguinal, epigastric, umbilical (adults, non-recurrent)
___ ischiorectal abscess
___ rectal polyp
___ varicose veins
___ pilonidal cyst, marsupialization
___ appendectomy
___ Barrows ligation
___ breast, open biopsy
___ biopsy lymph node, axilla or groin

GYNAECOLOGY

___ marsupialization Bartholin's cyst
___ tubal ligation
___ diagnostic D & C with or without cervical biopsy
___ D & C with or without polypectomy
___ D & C for retained products of conception
___ removal of caruncle
___ therapeutic abortion
___ ovarian cyst

CRITICAL CARE: This section applies only to hospitals with a designated unit. Please forward documentation with application.

___ ECG interpretation (U of Manitoba examination or equivalent)
___ Director of Unit: (2 months acceptable critical care medicine, ACLS, ATLS)

OBSTETRICS

___ D & C for incomplete abortion or retained products of conception
___ medical induction of labour, protocol required
___ vacuum extraction
___ high risk:
Breech ___ primipara
___ multipara
___ Caesarean section

OPHTHALMOLOGY

___ chalazion removal
___ dilatation of lacrimal duct

ORTHOPAEDICS

___ excision of ganglion
___ amputation of toes and fingers
Fracture care (closed reduction and immobilization)
___ radius and ulna
___ distal/mid-shaft fracture
___ fibula and tibia
___ nasal bones
___ hammer toe
___ removal of exostoses
___ extensor tendon repair
___ carpal tunnel
___ open correction of simple deformity, e.g. Hallux Valgus

OTOLARYNGOLOGY

___ reduction of deformity
___ myringotomy
___ sinus drainage, by trocar
___ removal of tonsils and adenoids
___ salivary incision and drainage

UROLOGY

___ circumcision (beyond newborn period)
___ hydrocele
___ vasectomy
___ urethral dilatation
___ cystoscopy
___ needle biopsy of prostate

___ OTHER (indicate on reverse if necessary)

PHYSICIAN

FACILITY

CHIEF OF STAFF SIGNATURE

COLLEGE APPROVAL

SCHEDULE C - [illegible]

This form is intended to be used in the allocation of elective procedural privileges. In emergency situations, individual clinical judgment must prevail.

CREDENTIALS: Canadian Certification (alternative as defined by Clinical Privileges Panel).

DISCIPLINE

___ esophagectomy
___ gastrectomy
___ bronchectomy
___ cystectomy
___ colectomy
___ nephrectomy
___ pulmonectomy
___ splenectomy
___ ERCP

GENERAL SURGERY

Breast Surgery

Gastrointestinal*

Pancreaticobiliary

Head and Neck**

Cardiovascular and Thoracic

Peripheral

Coronary

ORTHOPAEDICS

___ anterior and posterior repair
___ cold coagulation - cervical cytology
___ hysterectomy
___ Manchel/Fothergill
___ simple excision

OPHTHALMOLOGY

___ flower tendon repair, hand
___ internal derangement of knee and other joints
___ open reduction of fractures/dislocations
___ operative treatment of compound fractures
___ replacement knee shoulder/hip for trauma or vascular insufficiency
___ arthrodesis other joints
___ drainage bone
___ bone graft

UROLOGY

___ ureterotomy
___ other surgery on ureters or urethra
Nephrectomy
___ partial
___ total
___ prostatectomy

ANESTHESIA

OTHER

EXCLUSIONS:

* : GI hernia or other surgery for morbid obesity due to need to control such procedures with high patient risk
: GI surgery on the rectum other than Resection
** : parathyroidectomy because it requires frozen sections
: extensive lesions involving a multidisciplinary approach, e.g. craniotomy and plastics, etc.

PRIVILEGES

FACILITY:

CHIEF OF STAFF RECOMMENDS

COLLEGE APPROVES: